

AUG 22 1990

JOSEPH E. SPANIOLO, JR.  
CLERK

No. 89-1391  
consolidated with 89-1392

(23)  
(22)

IN THE  
**Supreme Court of the United States**

OCTOBER TERM 1990

No. 89-1391

IRVING RUST, *et al.*,  
*Appellants,*

v.

LOUIS SULLIVAN, SECRETARY  
OF HEALTH AND HUMAN SERVICES  
*Appellee.*

No. 89-1392

NEW YORK, *et al.*,  
*Appellants,*

v.

LOUIS SULLIVAN, SECRETARY  
OF HEALTH AND HUMAN SERVICES  
*Appellee.*

On Appeal from the United States Court of Appeals  
for the Second Circuit

BRIEF OF AMERICAN LIFE LEAGUE, INC.,  
BERNARD NATHANSON, M.D.  
AND BERNADEL, INC. AS AMICI CURIAE  
IN SUPPORT OF APPELLEE

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## CASE

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MD, and JUDITH L WAGNER, PhD CHANGING  
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JAY S GREENSPAN, S DAVID RUBENSTEIN,  
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WILLIAMS TEXTBOOK ON OBSTETRICS (1945)  
14

# INTEREST OF AMICI

American Life League, Inc (ALL) is a  
c3 educational corporation which is  
probably the world's largest non church  
organization dedicated to the  
proposition of the Declaration of  
Independence "that all men are created  
equal, that they are endowed by their  
creator with certain unalienable Rights,  
that among these are Life..." ALL  
periodically distributes millions of  
copies of documents supporting the  
contention that being created equal  
gives the new individuals the Right to  
Life from the time of creation which is  
the time of fertilization when medical  
science agrees the new individual  
begins. The items published have  
included an analysis of the  
Reconstruction debates showing no intent  
to protect abortion via the Fourteenth



Amendment or to give any court the power to legislate its beliefs into law, an analysis of early Christian documents showing that all major Christian churches before the present generation condemned abortion, and an analysis of Title 1 USC Section 1 showing that Congress at the time of the Nazi War Crimes trials caused the definition of "person" to include "individual", because the term "individual" includes all humans, including the preborn.

If abortion has a father, that man is amicus Bernard Nathanson, MD. He was probably the leading theoretician of the abortionists when they developed the arguments that lead to the acceptance of abortion by segments of America. After legalization, he ran America's largest abortion facility and was associated with more abortions than any other

person. A few years after legalization, advancing medical knowledge and more refined ways to examine, understand and view the preborn human convinced him that for humanitarian non religious reasons abortion is wrong. He has since published the movie Silent Scream which shows a first trimester preborn human trying successfully for a short time, but ultimately unsuccessfully to dodge the suction tip of an abortion machine, and has republished medical articles showing that chemicals are present which appear to show some first trimester preborns feel pain when aborted.

Bernadel, Inc is an educational corporation monitoring published advances in medicine.

The consent of the parties to the filing of this brief has been obtained and is filed herewith.

## SUMMARY OF ARGUMENT

The abortion battle is a conflict between the enumerated Right to Life and the unenumerated right to abortion.

Viability relates to all patients, not just infants. Viability measures the ability to treat the patient or infant, not the inherent characteristics or humanity of the patient or infant. Viability related to premature infants has so improved since 1973 that many thousands of infants have recently been aborted at ages where where they may have been considered non viable in 1973, but today they would have a better than 90% chance to survive if separated non violently from there mother. Recent advances in medical science indicate that this year, 1990, potential viability could be as early as the end of the first trimester.

This brief discusses advances in treatment of extremely premature preborn humans published too late to be referenced in briefs filed in abortion cases heard last term. It outlines recent relevant medical articles. It assumes that viability may have two related but different meanings:

- 1] that age at which it is possible for a preborn human to survive if non violently expelled from the uterus; or
- 2] that (older) age at which most non violently expelled humans survive.

POSSIBLE VIABILITY: It is believed that with present technology it is now theoretically possible for a twelve week gestation expelled human to survive. Because of the nature of problems related to experiments on human subjects, the technology, although proven on animals, has not yet been

tried on large numbers of young humans.

PROBABLE VIABILITY: It is believed that at the age of 23 weeks and weight of slightly more than one pound, infants are very likely to survive. In fact Madeline Mann, about half that size, was born in Chicago June 27, 1989 weighing 280 grams (10 ounces) and discharged healthy and with reasonable assurance that she would have no significant health problems. By the time the Court reads this brief, it is likely that even younger gestation infants will survive.

The new technology comprises improved ultra sound, oxygenated perfluorocarbons, lung sprays, blood recycling, and other techniques.

This Court has reversed its finding of Prudential Insurance Co v Check 259 US 530 (1922) that there was no Federal right to privacy and found that there

was after all a right to privacy that permitted abortion under conditions where the preborn human would be killed unconditionally to the moment of birth. Purported conditions permitting limiting of abortion after viability were impossible to implement within the impossibly narrow confines legislated by the Court. In 1983, the Akron dissent pointed out that we would soon have viability in the first trimester.

Arguably, we now do. Justice O'Connor in Akron urged recognition of the State's interest, thereby permitting states to restrict abortion throughout pregnancy.

If the Court now accepts the Akron dissent, it will remove from the Federal Courts many cases and from this Court about one annual difficult case, (based on numbers since 1973). If not, it will again sanction killing viable humans.



I VIABILITY AND THE ABORTION RIGHT

Justice O'Connor, [1] in Akron v Akron Ctr for Reproductive Health 462 US 416, 76 L Ed 2d 687, 103 S Ct 2481 stated in dissent (with Justice White and Justice Rehnquist joining):

[462 US 457] "In 1973, viability before 28 weeks was considered unusual....It is certainly reasonable to believe that fetal viability in the first trimester of pregnancy may be possible in the not too distant future. Indeed, the Court has explicitly acknowledged that Roe left the point of viability 'flexible for anticipated advancements in medical [462 US 458] judgment, skill, and [1] Akron v Akron Center for Reproductive Health 462 US 416, at 457-461, 76 L Ed 2d 687 at 720-723, 103 S Ct 2481 (1983)

technical ability, and we preserved the flexibility of the term.'....The Roe framework is clearly on a collision course with itself....As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception. Moreover, it is clear that the trimester approach violates the fundamental aspiration of judicial decisionmaking through the application of neutral principals 'sufficiently absolute to give them roots throughout the community and continuity over sufficient periods of time.'

[462 US 460] "In Roe, the Court held that [462 US 461] although the State had an important and legitimate interest in protecting potential human life, that interest could not become

compelling until the point at which the fetus was viable. The difficulty with this analysis is clear: potential human life is no less potential in the first weeks of pregnancy than it is at viability or afterward. At any stage in pregnancy, there is the potential for human life. Although the Court refused to 'resolve the difficult question of when human life begins,' id.. at 159, 35 LEd 2d 147, 93 S Ct 750, the Court chose the point of viability-when the fetus is capable of life independent of its mother-to permit the complete proscription of abortion. The choice of viability as the point at which the state interest in potential life becomes compelling is no less arbitrary than choosing any point before viability or any point



afterward. Accordingly, I believe that the State's interest in protecting human life exists throughout the pregnancy."

As will be shown infra, Justice O'Connor's 1983 future is now here.

Many factors decide elections. Nevertheless, to the extent the American people have exercised their choice as to the wisdom of the Akron majority in finding unenumerated Constitutional rights supporting abortion, as opposed to the wisdom of Justice O'Connor's Akron dissent, they have voted by landslide in favor of Justice O'Connor's 1983 Akron dissent. They have elected the more anti abortion candidate, the candidate of the anti abortion platform Republican Party in each recent presidential election. (In fact, Mr Bush was initially losing big in all polls.

Mr Bush won primarily by making two giant strides in popularity, the first associated in time with the publication of the Republican platform which supported the dissent position in Akron, and the second when he announced his anti abortion position.)

Most of more motivated Americans seem to agree with the Akron dissent. The largest (about 100 times as large as typical polls) recent poll of about 300,000 self selected readers of Parade Magazine, [1A] found 56% agreeing: "Abortion after the instant of conception is murder"; 80% disagreeing with the present unlimited abortion right; 61% disagreeing with even a first trimester abortion right, and 72% disagreeing with a second trimester abortion right.

[1A] Parade Magazine 8/19/90, Page 9

## II HOW AND WHY VIABILITY HAS CHANGED AND WILL CHANGE

Viability changes are important at least because most Americans do not want an unenumerated Constitutional right to abort and therefore kill a human who could or probably would survive if separated from her mother in a less destructive manner.

Accordingly, this Court may wish to consider the effect of its decision in the near future as younger premature infants become viable at presently non viable ages and weights. It is possible that prematurity early in the next century will not affect possible viability.

Scientists had fertilized human ova decades ago, but were unable to cause any to survive to birth. Fertilization in a dish followed by implantation in the uterus has since made the recently

fertilized ovum possibly viable. So fetal viability has increased not only from the mature end, but also from the young and immature end since 1973. Viability may continue to increase from the immature end.

At the other (mature) end, probable viability is defined in the sense that if separated from the mother in a non violent fashion, the infant would have a better than even chance to survive. Probable viability has gone down from perhaps 28 weeks in 1973 to about 22-23 weeks today and perhaps even younger in the best facilities.

There are at least two definitions of possible viability, (1) the youngest premature human who has survived and (2) the youngest human who should have a chance to survive given ideal conditions and the use of those relevant techniques and instruments which have at least been

proven on non human animals.

By definition (1), possible viability is in 1990 somewhat less than twenty weeks. A twenty week premature infant weighs about one pound (16 ounces). Madeline Mann was born weighing only 10 ounces (about half the weight of a twenty week premature infant) in a Chicago hospital June 27, 1989. She was discharged home October 26, 1989, apparently healthy and normal.

In addition, when we discuss weeks, we should note that the pregnancy is frequently dated from the last menstrual period which would probably have been at least two weeks before fertilization of the ovum that made the new individual and therefore is two weeks greater than the premature infant's actual age.

If we make the very simple but reasonable assumption that the trends in improvement of viability will continue

as they have since 1973, probable viability is decreasing from the more mature end at a rate of at least six weeks per twenty years. If this past trend continues, in 2010 AD probable viability will be about 15 weeks, in 2030 AD about 9 weeks, and about 2050 AD probable viability in the sense that the premature infant will probably survive to be discharged from the hospital will extend throughout the pregnancy. Sixty years (until 2050) is not long in the desired lifetime of a good Constitutional law decision, even if based in part on scientific knowledge.

Many medical techniques are first tried on animals. It is considered that veterinary science usually leads human medical science by 5-10 years. The reason is that initial experiments are frequently very dangerous for the subject and just not done on humans



until after having been proven on non human animals. We can nevertheless frequently say that the success of a technique in animal experiments indicates that it would probably work on human subjects. From this it follows that today in 1990 the human premature infant of 12 weeks or less is possibly viable as indicated by the viability of equivalently mature animals in experiments which have not yet been done on humans, but could be performed in a sufficiently desperate case.

The premature human who is substantially certain to survive today is not different just before birth from the premature human of five or more years ago of identical weight, maturity and other characteristics who could not survive. Viability is in no way a measure of the humanity of the premature human. Viability is a measure of our

ability to care for the weak, premature, ill or injured human. Because knowledge and new techniques, medicines, equipment, etc, spread from initial experimental treatment facilities to other facilities, past viability is always lower than present viability and average viability is always lower than viability at better equipped or staffed facilities. For this and other reasons, studies may have apparently differing results because of differing implicit definitions of terms, which differences are not obvious from comparison of the studies.

Viability in the near future will probably change in a manner similar to the way it has changed in the recent past, partly through an evolutionary procedure but with an occasional major breakthrough.

The breakthroughs may comprise the

invention of a new medicine, instrument, etc, such as liquid oxygen carrying which makes it possible to offer treatment today that was not possible yesterday.

The evolution usually comprises the use of a new technique or combination of techniques which may comprise the use of one or more new or old medicines, instruments, etc first at one hospital, followed by success, publication, and use at other facilities.

By the nature of the improvement in viability enhancing techniques, yesterday's not viable but almost viable infant becomes today's just barely possibly viable infant who becomes the near future's probably viable infant and subsequently becomes routinely viable.

To the extent the past can teach us the future, one hospital tries something

which works, so the previously impossible (not viable) situation changes, and although all other data at the time would indicate a zero chance of viability, viability is no longer impossible. Over a period of time, the new technique, medicine, equipment, etc becomes available at more and more hospitals so that these better equipped hospitals have a recent viability record equal to the potential of the new system less reductions for items such as their inexperience, while other, perhaps most hospitals may still have a zero viability record. At that time, the viability of an appropriate premature infant may vary from zero percent at nearly every hospital to a much higher percentage chance, perhaps as high as 90% or more at appropriate hospitals.

#### AGE AT SUBSTANTIALLY CERTAIN SURVIVAL

As noted previously herein and by this Court in Akron supra [1], viability before 28 weeks was considered unusual in 1973. The present unenumerated abortion right seems to be based on that soon after 1973 obsolete evaluation.

Immature infant viability has been constantly improving for many years. Viability defines not the humanity of the preborn or premature human but the sophistication of the techniques used to care for premature infants or others. The obstetrical textbook amicus Dr Nathanson used, stated: [2]

[2] Williams Textbook on Obstetrics (1945) "Children born at this period [33 weeks, weighing 1900 grams or 4 pounds, 3 ounces] may live if properly cared for although their chances are not very promising."

The definition of viability of premature human babies has been changing for years as follows: One of today's not viable babies survives via new technique or equipment, so that viability changes. The technique or equipment proves its usefulness and is widely adopted.

This section considers not a 28 week premature, but babies about half that size, to 23 weeks, most of whom are slightly greater than one pound in weight. Today, a 23 week premature will probably survive. Ferrara, et al [3]  
[3] Changing Outcome of Extremely Premature Infants (26 weeks Gestation or less and 750 Grams or less: Survival And Follow-Up At A Tertiary Center B  
Ferrara, R Hoekstra, E Graziano, G Knox, R Couser, and J Fangman published in American Journal of Obstetrics and Gynecology, (1989) 161: 1114-1118



have published part of the trend in the 1980's in the following table, Figure 1:

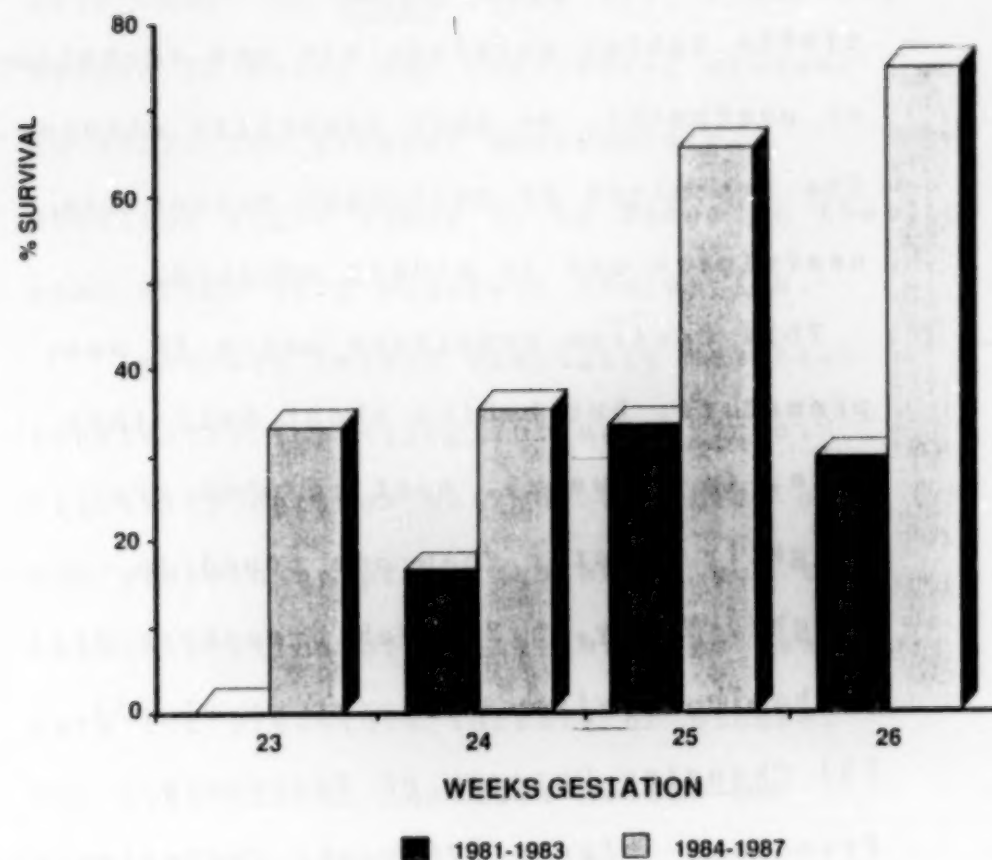


Figure 1. Demonstration of improved survival at each comparable gestational age in 1984-1987 compared with 1981-1983. Log-linear model,  $p = 0.005$

In 1981-1983, an insignificant number of 23 week infants survived.

During the next four year period, 1984-1987, more than thirty percent survived, a higher survival percentage than of 26 week prematures in 1981-1983. The trend continues. Today, a 23 week premature infant born (not any place, but in a properly equipped hospital) has a better than even chance to survive. Incidentally, approximately 75% of those babies who survived these extreme states of prematurity ultimately emerged healthy and neurologically intact.

Ehrenhaft, et al: [4]

[4] Changing Prognosis for Very Low Birth Weight infants Polly Ehrenhaft, MPH, Roger C Herdman, MD, and Judith L Wagner, PhD (from the Office of Technology Assessment, Congress of the United States) published in *Obstetrics and Gynecology*, September 1989, Vol 74: 528-535

have studied perinatal and neonatal morbidity and mortality trends in the US over the past 30 years. They conclude that there has been a dramatic improvement in both categories. Perhaps the most remarkable advance has been made in the 750-1000 gram group (1 pound, 10 ounces to 2 pounds, 3 ounces) in which there was at the time of the study a 70% survival rate (in contrast to the 35% survival rate 10 years earlier), and only 15-20% of these survivors will be left with severe handicaps (cerebral palsy, mental retardation, blindness, seizures, etc).

In the 1000-1500 gram group (2 pounds, 3 ounces to 3 pounds, 5 ounces) survival rates have risen from 50% in 1961 to 90% at the time of the study. 10% of those surviving babies were left with serious handicaps.

In the youngest group studied, 500-750 grams (1 pound 1 ounce to 1 pound, 10 ounces) which includes those considered totally non viable a short time ago, the Columbia-Presbyterian Medical Center in New York City indicated that there was a survival rate of 25-50% in the 500-750 grams group. 25% of the survivors had serious handicaps. The authors concluded:

"This review of the literature supports the conclusion that at least for very low birth weight infants neonatal mortality rates have continued to decline dramatically through the 1980's. Mortality has declined in every very low birth weight group..."

Reported and published data like the preceding lags a few years behind what is actually happening at any time. The

improvements from 1981-1983 to 1984-1987 have continued so that a similar table for 1988-1990 would probably show most 23 week premature infants surviving. These infants nearly all would have died in 1981-1983. 1990 is going to be better than the preceding years and some hospitals do better than others, so it is almost certain that in the best hospitals as you read this, a premature infant at the end of the second trimester at 23 weeks has a better than even chance, possibly a 90% chance to survive. Even younger infants will probably survive, which should stretch the definition of probable viability back past 22 or 23 weeks into the heart of the second trimester.

Not that it should matter, but most of the infants who die, die very quickly after birth sometime during the first 48

hours. This means that the infants who die do not cost much, minimizing adverse financial impact.

The ratio of disabled survivors has not increased. This means that many who in former years would have survived with disabilities now survive without disabilities because our ability to prevent disabilities is also increasing. The ratio of disabilities among more mature birth survivors is decreasing. The ratio of disabilities among the youngest survivors is comparable to the ratio of disabilities among the youngest survivors of former years (who however were born at a more mature age). This indicates that we will probably continue to reduce the percentage of disabilities among the youngest infants who survive today and will not find finances much affected as viability improves.



## POTENTIAL TWELVE WEEK FETAL VIABILITY

Potential viability as used herein means that we now apparently have successfully proven all the techniques necessary for a 12 week (end of the first trimester) or younger fetus to survive and that in an appropriate case in 1990, using techniques, care and equipment we now have, it is possible that a 12 week fetus could survive independent of her mother. The odds may be heavily against such survival the first time the technique is tried on a twelve week fetus, but it can no longer be said that it is impossible for such a young premature infant to survive independent of her mother. There appear to be no technical reasons why survival of 12 week or even younger premature infants is not possible at the present time, even if unlikely until the

techniques now known are further refined. Amicus Nathanson, an expert in neonate care, believes it likely that such techniques will be successful this decade in every sufficiently equipped hospital.

Why has the too early premature infant died? By far the most common impediment to the survival of very low birth weight babies is respiratory distress syndrome (also known as hyaline membrane disease). In this condition the lungs of such tiny babies are undeveloped and inelastic, and they are intolerant of the tubes we place in their airways and of the oxygen we force down these tubes in high concentration and under high pressure (curiously oxygen at very high concentration and pressure can be poisonous to such little babies over a long period of time).

The solution is as follows:

Key term definitions include:

respiratory failure: the inability of the premature child to inhale and absorb oxygen in sufficient quantities;

air leak syndrome: a condition found more often in premature babies in which the inhaled air (and oxygen) leaks out of the lung before it can be absorbed into the blood stream;

neonatal respiratory disease:  
respiratory failure. Greenspan, [5]  
has performed an important experiment

[5] Liquid Ventilation of Preterm Baby, Jay S Greenspan, S David Rubenstein, Marla Wolfson, Thomas H Shaffer (from the Departments of Physiology and Pediatrics, Temple University School of Medicine, Philadelphia, PA) printed in The Lancet Nov 4, 1989, No. 8671:1095

and states in part:

"While advances in gas ventilation and surfactant replacement therapy have improved survival of premature babies, morbidity remains significant. Animal studies have demonstrated that ventilation with an oxygenated liquid perfluorochemical (PFC) supports gas exchange without deleterious consequences at ages where conventional techniques fail. (footnotes omitted) We report the application of liquid gas exchange and mechanics in a newborn baby.

A 28-week gestation, 12-day-old girl weighing 980 g with bilateral interstitial parenchymal disease was referred for management of respiratory failure and air-leak syndrome. She was treated with conventional and high frequency gas ventilation in an

attempt to diminish mean airway pressure and resolve air leaks.

Despite improvements in these indices during the first few days of this therapy there was by day 4

physiological evidence for rapidly escalating pulmonary barotrauma with respiratory failure. Two physicians independent of the research team decided that conventional therapy had failed. Institutional approval and informed parental consent were obtained for liquid ventilation as an investigational therapy....

The infant tolerated liquid ventilation well without change in vital signs....During intermittent liquid ventilation there was a striking and sustained increase in  $PaO_2$  and decrease in  $PaCO_2$  which was maintained for about 2 h after the

procedure. There was an accompanying increase in pulmonary compliance and decrease in pulmonary resistance.

A chest X-ray immediately after liquid ventilation revealed homogeneous distribution of PFC (seen as radio-opacities) and no evidence of air leaks....

Previous in-vivo studies have been on immature animals with no evidence of barotrauma. This infant with severe lung disease improved in pulmonary function. This response may be related to the reduction in interfacial surface tension and uniform distribution of liquid, as corroborated by chest X-ray and supported by animal studies. The physiological responses observed illustrate the feasibility of this procedure as a potential therapy for



neonatal respiratory disease."

Neonatal respiratory disease is synonymous with respiratory failure, i.e. the lungs of the premature infant are not competent to capture and absorb sufficient oxygen to keep the infant alive and healthy. This limitation is the leading cause of death and/or disability in premature infants.

Greenspan, et al [5 supra] perfused (bathed) the child's lungs with oxygen-bearing PFC instead of gaseous oxygen. The child tolerated this therapy surprisingly well and actually improved her oxygenation.

The mere concept represents the promise of a giant step forward in the treatment of the tiniest newborn infants. The authors indicate in the article that they have had impressive success with this treatment in animal

experiments. The authors do away with invasive tubes and gaseous oxygen and instead have provided a gentle bath of oxygen-loaded liquid to flow through the tiny air passages. The blood vessels in the lung then pick up the oxygen from the liquid flowing over them. This therapy can be conceived as supplying the tiniest and most needy premature infants with the equivalent of gills to allow them to survive and mature until they can breath naturally. There appears to be no reason why infants at least as young as 12 weeks and even younger in the first trimester cannot survive independent of their mother using this technique. (Other techniques can take care of other premature infant needs.)

The technology has been shown in a different situation which may have inspired the preceding research in a

recent film called The Abyss. At one point a diver must be lowered 30,000 feet to the ocean bottom. At that depth the pressures are so great that oxygen pumped into his helmet cannot be forced into the vessels of his lungs, and it appears that the diver will die of asphyxia almost immediately. Instead, an oxygen-bearing liquid is flooded into his helmet. This is precisely the technology used by Greenpan et al.

We can expect that this year and in the near future, other premature infants will receive this treatment. More will gradually be learned until this technique or a derivation of it will permit premature infants considered non viable in 1989 to first sometimes, then frequently, then routinely survive. This viability improvement is likely to reach the first trimester by the year 2000 AD.

## CONCLUSION

If the unenumerated abortion right is not eliminated and replaced with the Akron dissent or something similar, recent medical advances mean that this Court will be approving the killing for often trivial reasons of many innocent human beings mature enough to survive if expelled from their mothers in a less violent manner.

Respectfully submitted,

*Robert L Sassone*

ROBERT L SASSONE

Attorney for Amici

NOS 89-1391 and 89-1392 CONSOLIDATED  
IN THE SUPREME COURT OF THE UNITED STATES  
OCTOBER TERM, 1990

NO 89-1391 IRVING RUST, et al,  
Appellants,

v

LOUIS SULLIVAN, SECRETARY OF HEALTH AND  
HUMAN SERVICES  
Appellee.

and

NO 89-1392 NEW YORK, et al,  
Appellants,

v

LOUIS SULLIVAN, SECRETARY OF HEALTH AND  
HUMAN SERVICES  
Appellee.

State of California ) ss.  
City of Santa Ana, County of Orange )

Robert L Sassone, being first duly  
sworn on his oath deposes and says:

Robert L Sassone is a member of the  
bar of the United States Supreme Court  
admitted October 26, 1971. To his  
knowledge, on August 22, 1990, within the  
particular time and the permitted time  
for serving of said amicus brief pursuant  
to Rule 28.2 with first class postage  
prepaid 40 copies of the attached amicus  
brief in the present case properly  
addressed to the Clerk of the United  
States Supreme Court and three copies of  
said amicus brief to each party addressed  
as follows:

KENNETH W STARR  
SOLICITOR GENERAL  
OFFICE OF THE SOLICITOR GENERAL  
US DEPARTMENT OF JUSTICE  
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WASHINGTON DC 20201

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ROBERT L SASSONE, Affiant

Subscribed and sworn to before me on  
August 22, 1990

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Notary Public